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SENDING THE WRONG MESSAGE: THE CURRENT STATE OF MINNESOTA LAW RAISES MULTIPLE BARRIERS TO MEANINGFUL RESOLUTION FOR OUR ELDER POPULATION WHEN BRINGING MEDICAL MALPRACTICE CLAIMS

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I. INTRODUCTION

Statutes and regulations endeavor to direct behavior throughout society and allow injured individuals to recover for harm. However, the enactment of a particular law—or the absence thereof—can have other unintended consequences. What facially appears to facilitate resolution can, in practice, actually construct hurdles that inhibit this very goal. This paradox is especially prevalent in laws affecting the elder population in need of long-term care services, such as in a nursing home, assisted living, or other long-term care setting.

Older adults in long-term care facilities need legal services just like any other subset of our population but have a unique set of needs. When injuries occur in the long-term care setting, the older adult or a family member may seek accountability. Yet, they often lack the financial means or energy to bring a legal claim. A nursing home resident is not focused on enforcing his or her rights or suing the very company providing him or her with necessary care. The resident is often either unaware of a potential legal claim or is unable to contact an attorney, let alone retain one. Even if a claim is pursued, the current legal framework limits recovery and accountability for older victims. Without the ability to meaningfully pursue their legal claims, society sends the wrong message to older adults—essentially stripping them of voice under the current legal framework. Legal claims on behalf of the elder population range anywhere from breach of contract, retaliatory discharge, and medical malpractice, to violation of rights. This article explores the claim of medical malpractice, in particular, and highlights the barriers older adults encounter under Minnesota law in trying to resolve their claims. It concludes by offering some proposed changes to improve the legal landscape for our elder population.

II. BACKGROUND

The number of individuals age sixty-five and older is on the rise due to the fact that baby boomers—those born from 1946 to 1964—started to turn sixty-five in 2011. From 2000 to 2010, the number of Americans age sixty-five and over increased by 15.1%.[1] Among those ages sixty-five and over, the number of males age eighty-five and older increased by 46.5%, more than any other demographic.[2] In Minnesota, the number of people age sixty-five and older is expected to almost double between the years 2010 and 2030. In 2025, for the first time ever, the population in Minnesota of people age sixty-five and older is expected to exceed the population of children age five to seventeen for the first time ever.[3]

1. CARRIE A. WERNER, U.S. CENSUS BUREAU, THE OLDER POPULATION: 2010, at 1 (2011), http://www.census.gov/prod/cen2010/briefs/c2010br-09.pdf.

2. *Id.* at 4.

3. *Aging Overview*, MINN. COMPASS, http://www.mncompass.org/aging/overview (last visited May 8, 2016).

Given the recent increase in the older population, it comes as no surprise that the number of those needing long-term care[4] services is also on the rise.[5] However, the increase is reflected in the assisted living facilities and smaller group home models, while the number of individuals in nursing homes[6] has actually decreased. The percentage of the population age sixty-five and older in nursing homes was 5.1% in 1990, 4.5% in 2000, and 3.1% in 2010.[7] Nationwide in 2010, 1.5 million people were residents of a nursing home, with 1.2 million age sixty-five[8] and older and 74% female.[9] In Minnesota, the number of nursing home beds has actually decreased by 32% since 1975, from 45,448 to 31,190.[10] Minnesota has had a moratorium on building new nursing homes[11] for approximately the last thirty years, reflecting a public policy of encouraging people to stay in their homes.

The decrease in nursing home beds, coupled with an increase in the number of people needing long-term services, means an increase in other services. As a result, assisted living and smaller residential care homes have seen a large population increase. In Minnesota, unlike other states, assisted living facilities are not licensed.[12] Rather, the landlord registers the building as a "housing

4. For the purposes of this article, "long-term care" references nursing homes, assisted living facilities, group homes, or other multiple-resident facilities in which individuals receive home care services.

5. *See* WERNER, *supra* note 1, at 18.

6. For the purposes of this article, "nursing home" references facilities licensed by the Minnesota Department of Health as a nursing home, including a "skilled nursing facility" under 42 U.S.C. § 1395i-3, referring to facilities accepting Medicare funding; a "nursing facility" under 42 U.S.C. § 1396r, referring to facilities accepting Medicaid funding, and facilities licensed as Boarding Care Homes by the Minnesota Department of Health. *See* MINN. STAT. § 144.50 (2014).

7. *Compare* WERNER, *supra* note 1, at 18 tbl.7, *with* U.S. CENSUS BUREAU, THE 65 YEARS AND OVER POPULATION: 2000, at 7–8 tbl.8 (2001), https://www.census.gov/prod/2001pubs/c2kbr01-10.pdf.

8. It is worth noting that 300,000 nursing home residents were under age sixty-five. *See* WERNER, *supra* note 1, at 18.

9. *See id.*

10. As of March 24, 2015, the Minnesota Department of Health licensed approximately 374 nursing homes and twenty-six boarding care homes for a combined total of 31,190 beds. MINN. DEP'T OF HEALTH, 2015 DIRECTORY: LICENSED, CERTIFIED AND REGISTERED HEALTH CARE FACILITIES AND SERVICES I (2015), http://www.health.state.mn.us/divs/fpc/directory/2015mdhdirectory.pdf.

11. *See* MINN. STAT. § 144A.71.

12. *See* NAT'L CTR. FOR ASSISTED LIVING, ASSISTED LIVING STATE REGULATORY REVIEW 2013, at 102 (2013) [hereinafter ASSISTED LIVING REVIEW 2013], https://

with services" (HWS) unit, and a home care service entity comes in to provide services. A HWS registration notifies the public that the facility is serving the elderly, disabled, and vulnerable populations and includes assisted living settings, group homes, and facilities in which residents receive some type of home care service. As of March 2015, approximately 2225 HWS registrations were issued by the Minnesota Department of Health.[13] These registrations are up 55% from March 2009, when 1434 HWS registrations were issued.[14] In addition, the number of home care providers licensed in Minnesota grew from 1369 in 2009 to 1629 in 2015.[15] This shift to HWS and home care is significant, especially in Minnesota, because the consumer and resident must be aware that even though the assisted living facility or similar entity appears to be a 24/7 care model, such as in a nursing home, it is not. All "non-nursing homes" are bound by a landlord/tenant agreement with home care services coming into the HWS-registered building.

The ramification of this flexible and broad long-term care arrangement is that coordination of care may be lacking, which creates a greater risk of residents falling through the cracks of the system and suffering injury or harm. The regulations and laws surrounding home care—while significantly strengthened in recent years in Minnesota[16]—lack the clarity necessary to hold facilities accountable for such harm.

Another significant consideration related to long-term care for the elderly is the expected rise in mental health diagnoses. Currently, one in four older adults experiences a mental disorder

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www.ahcancal.org/ncal/resources/Documents/2013_reg_review.pdf.

13. MINN. DEP'T OF HEALTH, *supra* note 10, at I.

14. *Compare* LYNN AVES ET AL., MINN. HOUSE RESEARCH DEP'T, REGULATION OF HEALTH AND HUMAN SERVICES FACILITIES 9 (2010), http://www.house.leg.state.mn.us/hrd/pubs/hhsfacl.pdf (noting that HWS licenses totaled 1434 in 2009), *with* MINN. DEP'T OF HEALTH, *supra* note 10, at I tbl.2 (listing HWS licensures as 2225 in 2015).

15. *Compare* AVES ET AL., *supra* note 14, at 16 (noting the numbers of home care licensure classes A, B, C, and F, which add up to 1369 in 2009), *with* MINN. DEP'T OF HEALTH, *supra* note 10, at I tbl.1 (listing home care licensures as 1629 in 2015). Note that the system of home care licensure changed significantly in the 2013 legislative session, changing home care licensures from distinctions of A, B, C, and F to "basic" and "comprehensive" home care licenses, thus diminishing some ability to compare the number of licenses in 2009 to 2015. *See* Act of May 23, 2013, ch. 108, 2013 Minn. Laws 335, 335–73 (as codified at MINN. STAT. §§ 144A.471–.483).

16. *See* 2013 Minn. Laws at 335–73.

such as depression, anxiety, or dementia, and an estimated two-thirds of older adults with mental health diagnoses do not receive necessary treatment.[17] The number of older adults with mental health diagnoses is expected to double to 15 million by 2030.[18] In Minnesota, the number of individuals age sixty-five and older with Alzheimer's disease, the most common form of dementia, is expected to rise 34.8% from 2015 to 2025—from 89,000 to 120,000.[19]

With the increase in the number of older adults needing long-term care services and the increase in diagnoses such as Alzheimer's, comes greater vulnerability for residents.[20] With greater vulnerability comes greater potential for harm and injury. Laws and regulations exist for protection from such harms, such as the Omnibus Budget and Reconciliation Act of 1987 (OBRA '87), which established regulations for nursing homes.[21] While it is arguable that such regulations apply to assisted living and other long-term care models in Minnesota, the law does not present clear standards by which breaches of the standard of care can be measured in the home care setting.[22] When accountability for such harm is pursued, whether in the nursing home or home care model, the law provides barriers to resolution that diminish the voice of the older population.

III. ISSUES

A majority of long-term care providers in Minnesota are performing great services to the older population. They face adverse circumstances yet strive daily to meet the needs of

17. *Healthy Aging Fact Sheet*, NAT'L COUNCIL ON AGING, https://www.ncoa.org/wp-content/uploads/FactSheet_HealthyAging.pdf (last updated Jan. 2014).

18. *Id.*

19. *2015 Alzheimer's Disease Facts and Figures*, ALZHEIMER'S ASS'N, http://www.alz.org/facts/downloads/facts_figures_2015.pdf (last visited May 8, 2016).

20. *See, e.g.*, CTRS. FOR DISEASE CONTROL & PREVENTION, LONG-TERM CARE PROVIDERS AND SERVICES USERS IN THE UNITED STATES: DATA FROM THE NATIONAL STUDY OF LONG-TERM CARE PROVIDERS, 2013–2014, at 40 (2016), http://www.cdc.gov/nchs/data/series/sr_03/sr03_038.pdf (documenting Alzheimer's disease incidence across care settings).

21. Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, 101 Stat. 1330 (1987) (codified as amended at 42 U.S.C. §§ 1395i-3(b)(4), 1396(b)(4)); 42 C.F.R. § 483.25 (2015). *See generally* 42 U.S.C. ch. 7 (2012); *id.* § 1302.

22. *See generally* MINN. STAT. ch. 144A (2014).

residents. Innovative ideas in long-term care continue to be pursued to reduce risk of harm and to improve services. However, injuries and death still occur. Based on this author's experience in bringing medical malpractice claims against long-term care facilities, most injuries in long-term care facilities center on four main themes: (1) lack of training; (2) lack of equipment; (3) lack of staffing; and (4) lack of coordination of care. Common injuries include falls, pressure sores, infections, and medication errors. Less common, but on the rise, are assault (including sexual assault), abuse, and drug diversion via taking of the elders' medication. The ramifications of injury in a vulnerable population have a spiral effect. The resident who falls and experiences a hip fracture at age eighty-five or ninety may never walk again because he or she is not a candidate for surgery and is unable to regain strength to fully heal. An unchecked pressure sore on the feet can lead to gangrene and amputation, particularly for someone with peripheral vascular complications. Knowledge of the preexisting conditions do not excuse poor care but rather allow for increased notice to provide good care to account for the risk factors present.

Today, many providers split out their approach to care, particularly with the home care model. The home care provider that is a main presence at the facility or at home often performs the activities of daily living but not skilled care, such as wound care.[23] A wound care provider comes in specifically to treat the wound but not to provide other services, even in nursing homes at times.[24] A hospice team often comes in separately from the nursing home or home care staff.[25] The resident already likely has a doctor who makes quarterly (or sometimes monthly) rounds and a nurse practitioner that may see the resident monthly. Fractionated care often means that a particular care issue gets lost in the shuffle and the resident suffers. No sole provider or care facility sees themselves as having the responsibility to follow through on

23. *See generally* ASSISTED LIVING REVIEW 2013, *supra* note 12.

24. For more information on wound care, see *Publications,* JEFFREY M. LEVINE, http://jmlevinemd.com/publications (last visited May 8, 2016); *Educational and Clinical Resources*, NAT'L PRESSURE ULCER ADVISORY PANEL, http://www.npuap.org/resources/educational-and-clinical-resources/ (last visited May 8, 2016).

25. *See, e.g.*, Matthew E. Misichko, *A Help-Ing Hand: How Legislation Can Reform the Affordable Care Act and Hospice Care to Prioritize Comfort and Prepare for the Baby Boomer Generation*, 21 ELDER L.J. 419, 431–32 (2014) (noting the congressionally intended separateness of hospice care from nursing home care).

ensuring that a condition is not worsening or reporting changes in condition. Changes in condition present one of the greatest challenges for providers. Under 42 C.F.R. § 483.10(b)(11)(i), the provider has the duty to notify a resident's physician and family member about any changes in condition.[26] This one duty becomes extremely challenging with multiple providers involved in care, yet the duty remains and the resident relies on the facility to intervene when harm arises.

Regardless of how and why injury or death occurred, the law allows older adults, just like their younger counterparts, to seek redress through the courts. Theoretically, the older adult could bring a claim of medical malpractice and seek damages for injury as a result of a breach of standard of care. The older adult has the time, resources, and capacity to hire an attorney to seek compensation. Theoretically, the injury could be isolated to the particular breach and experts could testify as to what medical conditions are related to the injury. The courthouse doors provide equal opportunity to older adults to work through the process to resolve the matter. Theoretically, the family members left behind after a death are able to pursue the claim on behalf of their loved one, including getting medical records to investigate the harm done. Theoretically, the claim moves swiftly to resolution prior to the death of an older plaintiff. However, the human dynamic of medical malpractice claims on behalf of the elderly against long-term care providers is not confined to theory. In the real world, the voice of the elder is squeezed out by the practical implications of the law.

There are many practical barriers in medical malpractice claims brought by older adults against long-term care facilities. These barriers can be insurmountable in some cases, or more minor in others. But they nevertheless impede resolution in a manner not experienced by other age or ability groups. Legislators did not contemplate the impact of such laws on the older population, and that by highlighting these barriers, improvements can eventually be made in valuing the voice of the older population in the face of harm. Delay in medical malpractice claims on behalf of the elderly or vulnerable adults is extremely troubling given that if the elder dies, pain and suffering damages do not survive the decedent. This sends the wrong message to long-term care

26. 42 C.F.R. § 483.10(b)(11).

providers—that even if the resident dies in the face of egregious negligence, the claim will most likely go away.

Below are some of the barriers experienced by the older population when bringing a medical malpractice claim:

A. Providers Challenging Health Care Agent

> *Providers challenging that a health care agent has authority under a health care directive to make decisions as to care and at times to retrieve medical records, based on the principal lacking decision-making capacity.*

Minnesota Statutes chapter 145C sets forth the requirements for executing a health care directive in Minnesota.[27] In other states,[28] a health care directive is also called an advanced care directive,[29] health care power of attorney,[30] or living will.[31] The general idea is to formalize an individual's wishes for care and/or to appoint a health care agent to make health care decisions for the individual. A health care directive may list both health care instructions, as well as appoint a health care agent, but need only do one of the two.[32]

Under Minnesota's health care directive statute, in order for the agency appointment (or any instructions for that matter) to "vest," or become valid, the principal must lack decision-making

27. *See* MINN. STAT. ch. 145C.

28. Minnesota Statutes chapter 145C and the language of "health care directive" replaces Minnesota Statutes chapter 145B, which used the old language of a "living will." *Compare* MINN. STAT. ch. 145C, *with* MINN. STAT. ch. 145B. Although Minnesota Statutes chapter 145B still exists on the books, it applies only to living wills executed before August 1, 1998. *See* MINN. STAT. § 145B.011.

29. *E.g.*, ALA. CODE § 22-8A-4 (West, Westlaw through 2015 Reg., 1st Spec., and 2d Spec. Sess.); CAL. PROB. CODE § 4701 (West, Westlaw through 2015 Reg. Sess. and ch. 1 of 2015-2016 2d Ex. Sess.); MD. CODE ANN., HEALTH-GEN. § 5-601 (West, Westlaw through 2015 Reg. Sess. of Gen. Assemb.); 20 PA. STAT. AND CONS. STAT. ANN. § 5422 (West, Westlaw through 2015 Reg. Sess. Acts 1-96); TEX. HEALTH & SAFETY CODE ANN. § 166.002 (West, Westlaw through 2015 Reg. Sess. of the 84th Leg.).

30. *E.g.*, N.Y. GEN. OBLIG. LAW § 5-1501(2)(j) (McKinney, Westlaw through 2016).

31. *E.g.* 755 ILL. COMP. STAT. ANN. 35/1 (West, Westlaw through P.A. 99-495 of the 2015 Reg. Sess.); WIS. STAT. ANN. § 154.03 (West, Westlaw through 2015 Act 127).

32. MINN. STAT. § 145C.03, subdiv. 1(6).

capacity.[33] This means that before a health care provider may honor the agent's wishes or in some circumstances provide the agent with medical records, the provider may first determine whether the principal can make health care decisions on his or her own.[34] With all the emphasis on having a health care directive on file with the provider, most of the time the health care provider will simply honor the authority given in the directive and is glad to be able to talk with someone in authority to facilitate decisions. However, based on Minnesota law, the provider may challenge whether the grant of authority has officially been made by requiring a finding that the principal lacks decision-making capacity.[35] Minnesota Statutes section 145C.01, subdivision 1(b) defines decision-making capacity as: "[T]he ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision."[36]

Pursuant to Minnesota Statutes section 145C.02, the determination of decision-making capacity is to be made by the principal's attending physician[37]:

> A principal with the capacity to do so may execute a health care directive. A health care directive may include one or more health care instructions to direct health care providers, others assisting with health care, family members, and a health care agent. A health care directive may include a health care power of attorney to appoint a health care agent to make health care decisions for the principal when the principal, in the judgment of the principal's attending physician, lacks decision-making capacity, unless otherwise specified in the health care directive.[38]

The provider may challenge that the health care directive is valid when he or she legitimately becomes concerned about

33. *Id.* §§ 145C.01, subdiv. 1b, 145C.02, 145C.06.

34. *See id.* § 145C.08.

35. *See id.* § 145C.06.

36. *Id.* § 145C.01, subdiv. 1(b).

37. Minnesota Statutes chapter 145C does not define the term "attending physician"; however, it is presumed to mean the treating and/or primary care physician. *Compare id.* § 145C.01, *with id.* § 145C.07, subdiv. 1, *and id.* § 145C.06. Additionally, an "attending physician" may not act as a health care agent if the physician is attending to the principal on the date of the execution of the health care directive. *Id.* § 145C.03, subdiv. 2(b)(1).

38. *Id.* § 145C.02.

listening to the agent when the principal can adequately understand and communicate his or her wishes. However, the provider may also use this required finding of decision-making capacity to manipulate a result. For instance, when the provider disagrees with the agent's decisions regarding the principal's health, the provider may state that it will not honor the health care directive because the principal can speak for himself or herself, thus blocking the influence and instructions of the agent. This blocking can happen in the nursing home setting when the agent wants to send the principal to the hospital (or does not want to), and the provider believes otherwise.

One part of the health care directive is often authorizing the agent to receive medical records.[39] In fact, drafters of a health care directive should specifically include language that appoints the agent as a "personal representative" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), authorizing the agent to receive medical records (otherwise known as "protected health information"). If an injury occurs in a nursing home and the agent wishes to investigate the matter by reviewing medical records, the agent may be blocked from receiving medical records pending a determination by a physician that the resident lacks the requisite decision-making capacity.[40] As a further potential hurdle in the process, the resident likely utilizes the physician associated with the nursing home as a primary care and treating physician, so the possibility exists that the physician may simply say that the principal lacks decision-making capacity. Not to mention, the physician may visit once every three months and thereby delay getting an opinion on the principal's decision-making capacity.

Nothing in Minnesota Statutes chapter 145C precludes the agent from adding other wishes to the document, thus adding to or

39. *Id.* § 145C.08.

40. This author has experienced this delay in obtaining records, with the nursing home stating that because the resident moved to another facility, the facility could not honor the agent/claimant's request for medical records because it could not evaluate the former resident's current condition to determine if he or she lacked decision-making capacity, pursuant to Minnesota Statutes chapter 145C. The provider was willing to accept the written opinion of the former resident's current physician as to decision-making capacity, but the process caused considerable delay. Delay is the nemesis of elder medical malpractice claims in Minnesota, given that if the resident dies, pain and suffering damages do not survive the decedent.

amending statutory language.[41] In fact, Minnesota Statutes section 145C.02 specifically states that the agent is appointed when the attending physician determines that the principal lacks decision-making capacity, "unless otherwise specified in the health care directive."[42] Minnesota Statutes section 145C.05, subdivision 2(c) even more clearly states that "[a] health care directive may authorize a health care agent to make health care decisions for a principal even though the principal retains decision-making capacity."[43]

Therefore, to avoid the above delays, the drafter of the health care directive should: (1) ensure that HIPAA language is in the directive to allow for retrieval of medical records; (2) ensure that language for retrieval of medical records states that the agent has authority to do so, regardless of decision-making capacity; and (3) ensure that language regarding the appointment of the agent includes that an agent is appointed, regardless of decision-making capacity.[44] While perhaps not foolproof in eliminating inquiry into whether the appointment has occurred, it may reduce hurdles in recognizing the grant of authority in the health care directive.

B. Interpretation by Providers Concerning Medical Records Access

> *The interpretation by health care providers that once a person dies, the authority granted under the health care directive to retrieve medical records ceases.*

When a loved one dies, the family naturally seeks answers. They want to know what happened, how their loved one died, and who may have been present or involved. This is particularly so in a long-term care setting when the expectation is that the resident is in the nursing home or assisted living facility specifically for the purpose of preventing injury or death by getting around the clock care. Some facilities will meet with the family and attempt to explain as best they can what happened. However, other facilities

41. *See* MINN. STAT. § 145C.05.

42. *Id.* § 145C.02.

43. *Id.* § 145C.05, subdiv. 2(c).

44. Note that under some circumstances the health care directive should not include language by which the agent can act even if the resident has decision-making capacity, such as to prevent family members from making health care decisions that do not promote the best interests of the resident (based on the wishes of the resident).

will block information requests. This is particularly disadvantageous for bringing a medical malpractice claim since the plaintiff must seek review of medical records by a qualified provider who determines that negligence occurred prior to filing suit.[45] If the family is not able to get the medical records, they cannot get the requisite review to bring a claim.[46]

If the decedent had a health care directive allowing an agent to receive medical records, the provider will state that the ability for another to get medical records through the directive ceased upon death. However, that is not entirely true. Minnesota's health care directive statute does not specifically address whether the authority granted under the directive ceases upon death.[47] It certainly does not state that the health care directive ceases upon death, and in fact provides evidence that it is contemplated that the directive would continue after death. Minnesota Statutes section 145C.05, subdivisions 2(a)(5) and (7), suggest that the health care directive include instructions related to anatomical gifts and funeral directives, both of which would need to be carried out after death.[48]

The following authority specifically allows a health care directive to continue to be effective even after death.

1. Family Member if Government Entity

Medical records from a government hospital or entity are made available to the surviving spouse, parents, children, siblings, and health care agent of the decedent pursuant to Minnesota Statutes section 13.384, subdivision 3(e).[49]

2. Surviving Spouse, Parents, and Representative

Minnesota Statutes section 144.291, subdivision 2(g), defines a "patient" as the individual receiving treatment as well as the surviving spouse, parents, and representative of the individual.[50]

45. Minnesota Statutes section 145.682, subdivision 2 requires expert opinions in civil claims against a medical provider that allege a breach of the standard of medical care.

46. *See id.*

47. *See id.* § 145C.02.

48. *Id.* § 145C.05, subdivs. 2(a)(5), (7).

49. *Id.* § 13.384, subdiv. 3(e).

50. *Id.* § 144.291, subdiv. 2(g).

Minnesota Statutes section 144.292, subdivision 5, states that the patient must be given a copy of his or her medical records.[51]

3. Personal Representative Appointed Via a Will

Even absent the formal appointment of the personal representative of an estate, a provider must also provide protected health information to a person appointed as personal representative in a will. This right to medical records of a decedent is generally recognized in Minnesota due to the personal representative being specifically allowed access to medical records under Minnesota Statutes section 144.293, subdivision 2.[52]

4. Personal Representative of the Estate of the Deceased Individual

Under federal law, the provider must disclose protected health information, upon request, to the personal representative of the estate of the decedent.[53] In this case, the personal representative stands in the shoes of the decedent in making the request, as if the deceased individual made the request.[54]

5. Family Members Involved in the Care of Decedent Prior to Death

Effective March 26, 2013, the HIPAA/HITECH Act Omnibus Final Rules[55] went into effect, making several clarifications to what is known at the "Privacy Rule" under 45 C.F.R. § 164.[56] The Privacy Rule contains language that regulates the dissemination of protected health information.[57] As one of the clarifications of the 2013 Omnibus Rule, providers are to disclose the protected health information of a decedent to family members and others who were involved in the care or payment for care of the decedent, prior to death.[58] The term "involved in care" is defined as the provider

51. *Id.* § 144.292, subdiv. 5.
52. *Id.* § 144.293, subdiv. 2.
53. *See* 45 C.F.R. § 164.502(g)(4) (2015).
54. *Id.* § 164.502(g)(1).
55. *See* Modifications to HIPAA Rules, 78 Fed. Reg. 5566-01 (Jan. 25, 2013).
56. 45 C.F.R. § 164.
57. *See id.* § 160.103 (defining "protected health information").
58. The Code of Federal Regulations provides:

> If the individual is deceased, a covered entity may disclose to a family member, or other persons identified in paragraph (b)(1) of this section who were involved in the individual's care or payment for

having "reasonable assurance" that the family member was involved in the decedent's care.[59] However, the provider is not *required* to supply the requested information if the provider believes that disclosure is not appropriate; rather disclosure is *permitted.*[60]

C. Legal Authority to Get Decendent's Medical Records

If the provider will not recognize the legal authority to get medical records of a decedent, a trustee must be appointed to get medical records.

Even though the family should be able to get medical records on behalf of a decedent based on the aforementioned provisions listed in this article, the provider may yet resist disclosure of the medical records. Particularly with the newer Privacy Rule, disclosure of medical records to a family member who was involved with the decedent's care prior to death is allowed but not required.[61] At times, providers seem to utilize HIPAA privacy rules as a sword and not a shield when preventing disclosure of medical records in follow-up to an injury or death of a vulnerable adult. Pursuant to Minnesota Statutes section 573.02, subdivision 3, a trustee must be appointed to bring a legal claim of wrongful death, or of personal injury where the decedent's death is unrelated to the injury.[62] Being appointed as a trustee is distinct from being appointed as a personal representative of an estate. The authority of the trustee is generally recognized by providers as allowing disclosure of medical records.[63] However, it comes at a cost, both monetarily and—at times—personally, to even get the records for review of a possible injury or death claim.[64]

> health care prior to the individual's death, protected health information of the individual that is relevant to such person's involvement, unless doing so is inconsistent with any prior expressed preference of the individual that is known to the covered entity.

Id. § 164.510(b)(5).

59. *Id.* § 164.510(b)(1); *see* Modifications to HIPAA Rules, *supra* note 55, at 5615.

60. *See* Modifications to HIPAA Rules, *supra* note 55, at 5615–16.

61. *Id.*

62. MINN. STAT. § 573.02, subdiv. 3 (2014).

63. *See* Modifications to HIPAA Rules, *supra* note 55, at 5615.

64. *See supra* Section III.C; *infra* Section III.D.

D. Rejection of Authorization for Release of Medical Information

The provider's rejection of an authorization for release of medical information must meet the elements of compliance under federal law.

Under federal HIPAA regulations regarding the disclosure of protected health information, an authorization to release information must contain certain statements and information.[65] Persons seeking to receive information need not use the provider's own authorization. Instead, they can use an authorization that is in compliance with HIPAA regulations. The patient, by and through any designated third party, has a right of access to his or her protected health information.[66] Furthermore, the provider is to supply the requested information within thirty days.[67] While the authorization and right of access may be enforced through an administrative complaint through the Office of Civil Rights, such delay may prove costly to the elderly claimant.[68]

E. Appointment of Trustee Process Is Not Conducive to Elder Client

The appointment of trustee process itself is not conducive to the elder client.

As stated above, Minnesota Statutes section 573.02 dictates that a trustee be appointed to bring a wrongful death or personal injury claim on behalf of a decedent.[69] In other states, the personal representative of the estate of the decedent is authorized to bring the wrongful death or injury claim but not in Minnesota. Minnesota has a unique process of appointing a "trustee for the next of kin."[70] The process of trustee appointment is explained in the Minnesota General Rules of Practice, Rule 144.01, but the rule was not designed with elder decedents in mind, causing additional

65. *See* 45 C.F.R. § 164.508(b)–(c) (2015).

66. *See id.* § 164.524(a).

67. *Id.* § 164.524(b)(2)(i).

68. *See generally HIPAA What to Expect*, U.S. DEP'T HEALTH & HUM. SERVS., http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html (last visited May 8, 2016).

69. *See* MINN. STAT. § 573.02, subdiv. 3 (2014).

70. *See* Ortiz v. Gavenda, 590 N.W.2d 119, 122 (Minn. 1999).

hurdles to bringing such a claim likely not intended under the law.[71]

First, the trustee appointment requires notification to the next of kin of the decedent, defined as the living spouse, parents, children, grandparents, and siblings of the decedent.[72] When the elder client is often age seventy-five or higher, notifying the siblings of the decedent can pose a problem. Oftentimes those siblings are in nursing homes or advanced in years themselves, with little connection to the decedent at this phase in life. Knowing their current contact information is the first challenge. Getting a signature for any consent to an appointment of trustee poses another challenge, given that the person may not have an attorney-in-fact appointed to sign documents and the elderly sibling may not be able to sign themselves. Generally, if all next of kin consent to the appointment, the court will appoint the trustee without a hearing.[73] However, a hearing may be necessary if consent is unobtainable due to the advanced age of a sibling, which further adds to the expense of appointing a trustee. Remember that the appointment may be sought to simply get authority to receive and review medical records for the possibility that a claim may be brought. More often than not, the siblings want nothing to do with the legal claim and appointment of trustee, but the law requires that the trustee represent the elderly sibling.

Second, if a claim is brought by the trustee, any settlement or award must be disclosed to the next of kin to allow them to consent to the distribution and/or have an opportunity to be heard in a court hearing. Given that most of the time the siblings are uninvolved with the decedent, it is often reasonable for them to receive no recovery. However, the trustee runs the risk that a sibling—if able—may object to little to no recovery and thus change expectations of the next of kin as to recovery. For example, usually the children are bringing the claim and divide any award amongst themselves, given the lack of connection of the decedent to his or her siblings at that time.

Finally, in an older resident, second marriages, adopted, or long-lost children are not uncommon. In one case, the decedent had long ago ceased contact with his biological children for several

71. MINN. GEN. R. PRAC. 144.01.
72. *Id.* R. 144.01.
73. *Id.* R. 144.02.

reasons, yet the stepfather of the children did not adopt them. The children were difficult to locate and the process brought about many painful memories regarding a father they never really knew who was now tragically dead as a result of an incident in a nursing home. Determining who are the next of kin is a process in and of itself that is quite complex given decades' worth of family dynamics. Again, the risk is not simply in getting a trustee appointment but also in agreement as to any distribution. Families in conflict over distribution due to dredging up past painful memories diverts the attention from the true focus of the trustee and wrongful death process—standing in the shoes of the decedent to seek accountability for a breach of standard of care, not punishing the family for past disagreements.

F. Pain and Suffering Damages in Minnesota

There are no pain and suffering damages in Minnesota once the resident dies, which sends the wrong message to providers of long-term care.

Under current Minnesota law, the greatest disadvantage to elder clients is that there is no meaningful way to account for injury once the client dies—namely because, under Minnesota law, the pain and suffering of the decedent does not survive.[74] Thus, one of the main measures of damages for the client dies with him or her. While death due to negligence is always tragic, pain and suffering damages may not be missed as sorely as in a claim involving a younger plaintiff. Unlike younger, employed plaintiffs, the elder client is not employed at the time of injury and cannot collect lost wages, loss of earning capacity, or often future medical costs. Available damages in a wrongful death claim involving a nursing home resident, for instance, are generally the medical bills; funeral bills; and the loss of aid, comfort, and society to family members left behind.[75] The pool of damages is not that large to begin with

74. Fussner v. Andert, 261 Minn. 347, 351–52, 113 N.W.2d 355, 358 (1961) (ruling that damages in a wrongful death action are for pecuniary loss and not for pain and suffering); Bremer v. Minneapolis, St. Paul & S.S.M. Ry. Co., 96 Minn. 469, 470, 105 N.W. 494, 494 (1905) (quoting Hutchins v. St. Paul, Minneapolis & Manitoba Ry. Co., 44 Minn. 5, 9, 46 N.W. 79 (1890)) (noting that damages cannot be awarded for pain and suffering).

75. *See, e.g.*, Martz v. Revier, 284 Minn. 166, 170 N.W.2d 83 (1969); *Andert*, 261 Minn. at 351–52, 113 N.W.2d at 358.

for a claim brought by the family of the resident. Even if future medical bills were able to be determined, given the multiple diagnoses and conditions suffered by the resident, the shorter anticipated life span would limit any future damages significantly. In addition, valuation of the loss of aid, comfort, and society of the next of kin does not make sense when the elder resident is at the time of life when family members give to the resident, not the other way around. While the loss of any loved one, no matter the age, is devastating, the law contemplates loss and calculates damages based on the middle-aged father of three and not the eighty-five-year-old great-grandmother.

Perhaps the most significant effect of not allowing pain and suffering damages to survive the decedent is that without other meaningful damages available to the injured elder, providers of long-term care have little incentive to resolve claims. They may simply delay the claim until the person dies and the claim essentially goes away. Only special damages[76] are available in an injury claim where the decedent died of causes unrelated to the injury. If the resident experienced abuse or neglect, yet did not receive medical treatment or incur medical bills, Minnesota Statutes section 573.01 states:

> A cause of action arising out of an injury to the person dies with the person of the party in whose favor it exists, except as provided in section 573.02. All other causes of action by one against another, whether arising on contract or not, survive to the personal representatives of the former and against those of the latter.[77]

The exception referenced in the above statute is for the wrongful death of the decedent[78] and personal injury where the death was from causes unrelated to the injury.[79] Even under an injury claim with a death from unrelated causes pursuant to section 573.02, subdivision 2, the only available damages are special damages for the injury, not pain and suffering.[80] For the wrongful death claim, the available damages are pecuniary damages under

76. Special damages are generally considered "economic damages" such as medical and funeral bills. *See* Range v. Buskirk Constr. Co., 281 Minn. 312, 318, 161 N.W.2d 645, 649 (1968).

77. MINN. STAT. § 573.01 (2014).

78. *Id.* § 573.02, subdiv. 1.

79. *Id.* § 573.01, subdiv. 2.

80. *Id.*

subdivision 1.[81] Pecuniary damages do not include the pain and suffering of the decedent under Minnesota law.[82] All other causes of action related to injury die with the decedent.

G. Expedited Litigation and Risk of Death Affects Available Damages

> *A greater need for expedited litigation and a higher risk that the elder resident will die during the pendency of the claim significantly affects available damages.*

As previously discussed, there is little incentive for a provider to mediate or otherwise work efficiently to resolve an injury claim when the available damages change significantly upon death with the inability to recover for pain and suffering. However, if the parties cannot resolve the matter swiftly, at minimum, all courts should accommodate an expedited litigation process to keep the claim moving forward in a timely manner given the inherent disadvantage the elderly client faces. Yet, expedited litigation is not formally recognized in Minnesota courts for a medical malpractice case. The court system is currently piloting a mandatory expedited litigation track in Dakota and St. Louis County District Courts for certain civil claims but not medical malpractice.[83]

H. Mediation May Not Be Ordered by a Judge

When the court does not order the parties to mediation, it works another significant disadvantage on elderly clients. Courts generally favor ordering the parties to mediation prior to going to trial to see if the parties can resolve the matter. In medical malpractice cases, the court is to require the parties to discuss whether the parties may agree upon alternative dispute

81. *Id.* § 573.02, subdiv. 1.

82. *See* Skifstrom v. City of Coon Rapids, 524 N.W.2d 294 (Minn. Ct. App. 1994) (explaining the difference between general damages and pecuniary damages).

83. *See* MINN. JUDICIAL BRANCH, SPECIAL RULES FOR THE PILOT EXPEDITED CIVIL LITIGATION TRACK, http://www.mncourts.gov/Documents/0/Public/Rules/Special_Rules_for_Pilot_ELT.pdf (last visited May 8, 2016). Arguably injury claims against a nursing home, assisted living facility, and home health care provider are considered medical malpractice claims pursuant to Minnesota Statutes section 145.61. However, some injuries—such as abuse and neglect—have common-law injury standards and, at a minimum, those claims should be made available to expedited litigation tracks as currently defined by the courts.

resolution.[84] At times the court may not order mediation or another form of alternative dispute resolution unless the parties all agree to such a proceeding.[85] Not ordering mediation is a great disservice to the plaintiff in a medical malpractice case involving an elderly claimant. The finite pool of damages, the impact on damages if a death occurs, and the distinction between medical malpractice in long-term care versus acute care settings all force parties into expensive and drawn out litigation. This effect runs afoul of public policies protecting vulnerable adults elsewhere in the law.

In addition, providers often try to force plaintiffs to alternative dispute resolution while not agreeing to the same at a plaintiff's request, revealing a disparity in power and unconscionable procedures. For instance, many binding, mandatory arbitration agreements are appearing in nursing home and assisted living contracts, usually presented as one signature required among many to admit the resident.[86] Such arbitration agreements affect the legal rights of the plaintiff; most notably, the ability to be awarded punitive damages may be limited in arbitration while a jury may award such punitive damages.[87] Providers are not averse to forcing alternative dispute resolution themselves, but they often object to being forced to mediation. Furthermore, under Minnesota Statutes section 484.73, the court is authorized to establish a mandatory,

84. Minnesota law provides the following:

> At the time a trial judge orders a case for trial, the court shall require the parties to discuss and determine whether a form of alternative dispute resolution would be appropriate or likely to resolve some or all of the issues in the case. Alternative dispute resolution may include arbitration, mediation, summary jury trial, or other alternatives suggested by the court or parties, and may be either binding or nonbinding. All parties must agree unanimously before alternative dispute resolution proceeds.

MINN. STAT. § 604.11, subdiv. 2.

85. *Id.*

86. *See* Marmet Healthcare Ctr., Inc. v. Brown, 132 S. Ct. 1201, 1203–04 (2012) (holding that the Federal Arbitration Act preempts any state law prohibiting arbitration provisions in nursing home contracts and ending a circuit court split on the issue). *See generally* Suzanne M. Scheller, *Arbitrating Wrongful Death Claims for Nursing Home Patients: What is Wrong with this Picture and How to Make it "More" Right*, 113 PENN ST. L. REV. 527 (2008).

87. *See* MINN. STAT. § 549.20 (providing guidance on punitive damages).

non-binding arbitration system.[88] While certain claims are excluded, medical malpractice is not excluded:

> Judicial arbitration may not be used to dispose of matters relating to guardianship, conservatorship, or civil commitment, matters within the juvenile court jurisdiction involving children in need of protection or services or delinquency, matters involving termination of parental rights under sections 260C.301 to 260C.328, or matters arising under sections 518B.01, 626.557, or 144.651 to 144.652.[89]

Particularly due to the increased use by providers of pre-dispute, binding arbitration agreements, the court should view ordering mediation as a means to level the playing field and should not allow providers to pick and choose when they wish to engage in a non-binding alternative dispute resolution process such as mediation. After all, the law does not force resolution at mediation.

I. Notification of Subrogation Interest Without Knowing Final Interest

The need to notify Medicare of a possible subrogation interest, and yet not knowing the final interest until after settlement

Virtually every elderly client has Medicare health insurance.[90] As with any health insurance company, a plaintiff's attorney must notify Medicare of the liability claim to determine any subrogation interest that needs to be paid back to Medicare. The rationale is that, if Medicare paid a medical bill on behalf of a beneficiary and the medical bill was incurred as a result of injury due to the negligence of another, Medicare is owed the payments made. The process for reporting, receiving related charges, and ultimately determining a final demand amount is complex and time-consuming. The most challenging piece in the process is not knowing the final amount of the Medicare subrogation interest until after settlement. This lack of knowledge makes it very difficult at times to get the client's authority to settle the claim because they are unsure how much will need to be paid to Medicare. Estimates of the subrogation interest are available before settlement, but

88. *Id.* § 484.73, subdiv. 1.

89. *Id.* § 484.73, subdiv. 2.

90. Medicare health insurance is available to those ages sixty-five or older. *See* 42 U.S.C. § 1395o(2) (2014).

Medicare reserves the right to add to the estimate up until the request for the final demand amount, which has indeed happened on numerous occasions.[91] Defendants routinely make proof of satisfaction of the Medicare subrogation interest a term of any settlement due to their own legal obligations when it comes to reporting a liability claim.

J. Claimant Not Receiving Benefit of Recent Case Law

> *A claimant not receiving the benefit of recent case law that indicates that any award not be reduced by the amount of Medicare subrogation payments.*

Injury claims where the claimant is an elderly client involve Medicare. Medicare makes payments related to the injury claimed on behalf of the claimant but often writes off between 50% and 75% of the bill. This means that if the hospital billed $50,000 in care related to the injury, Medicare may pay $25,000 and write off $25,000, meaning simply not paying the remaining $25,000 and not allowing the patient to be billed for that amount, resulting in the hospital simply adjusting their bill to $25,000, the amount paid by Medicare. Payments made by health insurance companies related to the injury on behalf of the claimant are generally called "collateral source" payments.[92] If the claim went to trial, the jury would hear about the full amount of any medical bills, not the amount of payments by a collateral source.[93] The collateral source payments are only presented in a post-trial motion to request a reduction of any award based on an offset for collateral source payments.[94] However, related payments made by Medicare are not considered collateral source payments because they are payments made under the Social Security Act pursuant to Minnesota Statutes

91. In this author's experience, the amounts added by Medicare to the final demand amount, over and above Medicare's estimate, range from hundreds to thousands of dollars.

92. MINN. STAT. § 548.251, subdiv. 1.

93. *Id.* § 548.251, subdiv. 5.

94. *Id.* § 548.251, subdiv. 2. The theory is that a plaintiff should not be allowed double recovery, meaning if a medical bill related to an injury totaled $1,000 and the health insurance company paid $800 (and wrote off $200), any jury award may be reduced by the court to $800, or the amount of the collateral source payment, offset by the amount in health insurance premiums for the two years prior to the injury paid by claimant. *See id.*

section 548.251, subdivision 1(2), and are therefore excluded.[95] *Renswick v. Wenzel* confirms that Medicare payments are not considered collateral source payments.[96]

However, most claims on behalf of an elderly claimant settle without a jury trial. There are no post-trial motions where the subrogation interest is revealed and no determination by the court that Medicare subrogation interests are not collateral source payments and that the claimant is entitled to the full amount of the medical bills under a *Renswick* analysis. Defendants have an obligation to report a Medicare subrogation interest.[97] Once reported, the claimant and defendant have an obligation to satisfy the subrogation interest. Defendants often press to see the detailed Medicare subrogation interest under the guise of their reporting and satisfaction obligation. Much of the time, the information is used to find out the actual amount owed by a claimant, and any subsequent settlement offers do not reflect the actual billed amounts the claimant is entitled to under *Renswick*, but rather the subrogation amount. With 50–75% write offs, the ability to have meaningful recovery is limited for the elderly claimant.

K. Good Faith Insurance Law Does Not Provide Proper Tools

> *Good faith insurance law in Minnesota does not provide the tools to keep a claim moving, such as distinguishing what is "reasonable" in a claim involving and elderly client.*

Minnesota law requires timely and appropriate responses from an insurance company in a liability claim, such as that involving an injury in a nursing home. Minnesota Statutes sections 72A.17 through 72A.32 regulate insurance practices and are intended to prevent an insurance company from being non-responsive and obstructionist when given notice of a claim.[98] When an attorney attempts to work in good faith with an insurance adjuster to resolve a medical malpractice matter, the insurance laws are intended to ensure that the insurance company also operates in good faith.

95. *Id.* § 548.251, subdiv. 1(2).

96. 819 N.W.2d 198, 211 (Minn. Ct. App. 2012).

97. Defendant's reporting duty arises out of the Medicare, Medicaid, and section 111 of the SCHIP Extension Act of 2007 (commonly referred to as Section 111 of the MMSEA).

98. MINN. STAT. §§ 72A.17–.32.

However, the good faith insurance laws do not take into account an expedited review or are loosely regulated without an understanding of the effect of delay on an elderly client. Below is a sampling of specific provisions of the good faith insurance laws that could be bolstered to ensure good faith in claims involving vulnerable adults.

1. Demanding Information that Would Not Affect Settlement[99]

As stated above, Medicare has reporting requirements for both claimants and defendants. However, the requirement refers to notifying Medicare of the claim; it does not refer to receiving detailed information about related Medicare payments. In negotiations with insurance companies or defense attorneys, sometimes no settlement offer will be made without receipt of not just the estimated Medicare subrogation interest but also the detailed listing of related payments made by Medicare. Defendants often want to see the detailed listing to argue that certain line items are not related and therefore any settlement offer will not include such line items. Such detailed information does not affect the settlement since the claimant (and by extension the defendant) is responsible for paying the subrogation interest in its entirety, regardless of what the defendant believes is related. Demanding a detailed listing goes beyond any necessary information that would affect settlements in violation of Minnesota Statutes section 72A.201, subdivision 4(9).[100]

2. Not Ensuring Prompt and Fair Processing of Claims[101]

Subdivision 1 states that rules governing the processing of insurance claims were adopted to "ensure the prompt, fair, and honest processing of claims and complaints."[102] The definitions of the terms are not defined in law, particularly as related to claims

99. *Id.* § 72A.201, subdiv. 4(9) (providing that it is an unfair practice for the insurance company to demand "information which would not affect the settlement of the claim").

100. *Id.*

101. *Id.* § 72A.201, subdiv. 1. Similarly, this delayed processing also violates Minnesota Statutes section 72A.20, subdivision 12(5), which prohibits failing to affirm or deny coverage within a reasonable period of time. *Id.* § 72A.201, subdiv. 12(5).

102. *Id.* § 72A.201, subdiv. 1.

brought by a vulnerable adult. To a client with multiple health issues and perhaps imminent death, "prompt" should be given special meaning. Special protections for vulnerable adults and elderly individuals are recognized elsewhere in Minnesota law, including a public policy of protecting vulnerable adults and awarding special damages for certain behavior against senior citizens.[103]

3. Failure to Acknowledge Receipt of Notice of a Claim[104]

Once notice of a claim is given, the name, phone number, and other contact information of the insurance analyst is to be provided within ten business days of receipt of the notice.[105] It is possible that the contact information is not provided for months, which violates this section and also delays the claim.

4. Failure to Act Reasonably Promptly upon Communications[106]

Once notice of a claim is made, the insurer must respond with reasonable promptness.[107] Delays in response to everything from a request for contact information to a response to a demand, can take six to nine months or more. Again, given the vulnerability of the elderly claimant and the substantial impact of pain and suffering damages being unavailable once the claimant dies, "reasonably promptly" should be defined under Minnesota's good faith insurance laws.

L. Plaintiff Ineligible as a Result of Settlement Amount or Jury Award

> *The possibility that an injured plaintiff on Medical Assistance may become ineligible for Medical Assistance as a result of any settlement amount or jury award.*

Long-term care residents receiving Medical Assistance[108] benefits must have less than $3,000 in assets to maintain their

103. *See id.* §§ 626.557–.5573; *see also id.* § 325F.71 (enhancing penalties for consumer fraud against senior citizens and disabled individuals).

104. *Id.* § 72A.201, subdiv. 4(1).

105. *Id.* § 72A.201, subdivs. 4(1)–(2).

106. *Id.* § 72A.20, subdiv. 12(2).

107. *Id.*

108. "Medical Assistance," Minnesota's version of Medicaid, means "payment of part or all of the cost of the care and services identified in section 256B.0625,

eligibility.[109] When an injury claim is made on behalf of an elderly client, any settlement disbursement or jury award must be disclosed to the county overseeing Medical Assistance eligibility.[110] The question remains how such a settlement or jury award will be counted by Medical Assistance and whether the resident can retain Medical Assistance benefits. The answer hinges on whether such award is considered an "available asset" to pay for the resident's long-term care, thus disqualifying him or her from Medical Assistance, or whether such an award is considered "unavailable" and not counted when determining ongoing Medical Assistance eligibility.[111]

A person over the age of sixty-five receiving Medical Assistance benefits in Minnesota is not allowed to place any settlement funds into a special or supplemental needs trust because those trusts are only available if the grantor or beneficiary is under the age of sixty-five.[112] However, pursuant to 42 U.S.C. § 1396p(d)(4)(C), a disabled person of any age may place funds in a pooled trust as an excluded asset not counted in Medical Assistance eligibility.[113]

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for eligible individuals whose income and resources are insufficient to meet all of this cost." *Id.* § 256B.02, subdiv. 8.

109. *See* MINN. DEP'T. OF HUMAN SERVS., HEALTH CARE PROGRAMS MANUAL ch. 19.05 (2015) [hereinafter HCPM], http://hcopub.dhs.state.mn.us/hcpmsrc/19_05.htm.

110. *See* MINN. STAT. § 256B.056, subdiv. 9(c)(3).

111. *See generally id.* § 256B.056 (discussing eligibility requirements for medical assistance and naming certain assets as "available").

112. *See id.* § 501B.89; *id.* § 256B.056, subdivs. 3b(a)–(b) (providing requirements of a supplemental needs trust); *see also* 42 U.S.C. § 1396p(c)–(d)(2012) (providing the requirements of a special needs trust).

113. The requirements of 42 U.S.C. § 1396p(d)(4)(C) in order to exclude assets from a pooled trust when considering medical assistance eligibility are as follows:

> (C) A trust containing the assets of an individual who is disabled . . . that meets the following conditions:
>
> (i) The trust is established and managed by a nonprofit association.
>
> (ii) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.
>
> (iii) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in section 1382c(a)(3) of this title) by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.
>
> (iv) To the extent that amounts remaining in the beneficiary's

Minnesota has historically not recognized the federal law on point, which considers a pooled trust to be an excluded asset.[114] However, recent litigation has paved the way for elderly clients to place any settlement funds in a pooled trust without the resident losing Medical Assistance eligibility.[115] Because the pooled trust practice is relatively new and not confirmed in all counties, the possibility exists that one county may yet consider the pooled trust funds to be an available asset and thus disqualify the resident for Medical Assistance benefits.[116] Such a finding would cause the resident to use the settlement funds to pay for long-term care prior to becoming eligible for Medical Assistance once more.[117]

The stripping of Medical Assistance benefits disadvantages the elder client in that the claimant may use settlement funds to pay the very nursing home that injured him or her for care. In addition, the required proof and correspondence necessary to qualify again for Medical Assistance may be beyond the claimant's ability, and no agent or family member may be available to assist.

M. Difficulty in Separating Damages for Pain and Suffering

There is difficulty in separating out damages for pain and suffering in a vulnerable resident.

As stated elsewhere in this article, damages in a medical malpractice claim involving the elderly claimant include medical bills, pain and suffering, and possibly other special or pecuniary

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> account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State plan under this subchapter.

42 U.S.C. § 1396p(d)(4)(C).

114. *See* MINN. STAT. § 256B.0595, subdiv. 1(j) (imposing a transfer penalty when transferring funds into a pooled trust for person over age sixty-five).

115. *See* Peittersen v. Minn. Dep't of Human Servs., No. 19HA-CV-11-5630 (Dakota Cty. Ct. Oct. 2, 2012) (reversing a prior holding by finding that a transfer of a seventy-three-year-old woman on Medical Assistance into a pooled trust for less than fair market value was arbitrary and capricious); *see also* Lewis v. Alexander, 685 F.3d 325 (3d Cir. 2012) (finding that state law was impermissibly more restrictive than the federal law with respect to pooled special needs trusts).

116. *But see* HCPM, *supra* note 109, at ch. 19.25.35.25 (providing support for consistent interpretation by every county of pooled trusts as an excluded asset).

117. *Id.*

damages.[118] Given that pain and suffering is one of the few damages available to the claimant, proving that element is significant. Yet due to the vulnerability of the resident—the very condition that caused them to need long-term care—the ability to prove pain and suffering can be difficult. For instance, defendants may argue that a client with dementia or quadriplegia feels no pain. A patient who is non-verbal may show a "zero" pain rating in the medical records, thus leading a person to the conclusion that the resident felt no pain, not taking into account that the resident cannot verbalize pain. Simply because the resident cannot verbalize pain does not mean that he or she feels none. Residents with dementia often exhibit behaviors that are indicative of the experience of pain. Again, the law disadvantages the elderly claimant when using traditional markers of pain and suffering in a non-verbal or wheelchair-bound client. Without other available damages, the law seems to re-victimize the vulnerable adult when he or she tries to seek accountability for harm.

N. Expert Review Not Designed for Claims Against Long-Term Care

Minnesota's expert review statute is not designed for claims against ever-evolving models of long-term care.

Minnesota Statutes section 145.682, subdivision 2, requires that a claim against a health care provider be reviewed by an expert who believes that negligence occurred, prior to bringing the claim:

> In an action alleging malpractice, error, mistake, or failure to cure, whether based on contract or tort, against a health care provider which includes a cause of action as to which expert testimony is necessary to establish a prima facie case, the plaintiff must: (1) unless otherwise provided in subdivision 3, paragraph (b), serve upon defendant with the summons and complaint an affidavit as provided in subdivision 3; and (2) serve upon defendant within 180 days after commencement of discovery under the Rules of Civil Procedure, rule 26.04(a) an affidavit as provided by subdivision 4.[119]

The statute goes on to state the conclusions of the expert that are necessary to bring the claim:

118. *See supra* Section III.F.
119. MINN. STAT. § 145.682, subdiv. 2.

> The affidavit required by subdivision 2, clause (1), must be by the plaintiff's attorney and state that:
> (a) the facts of the case have been reviewed by the plaintiff's attorney with an expert whose qualifications provide a reasonable expectation that the expert's opinions could be admissible at trial and that, in the opinion of this expert, one or more defendants deviated from the applicable standard of care and by that action caused injury to the plaintiff; or
> (b) the expert review required by paragraph (a) could not reasonably be obtained before the action was commenced because of the applicable statute of limitations. If an affidavit is executed pursuant to this paragraph, the affidavit in paragraph (a) must be served on defendant or the defendant's counsel within 90 days after service of the summons and complaint.[120]

The requirement of expert review has many ramifications for the elderly claimant, particularly as it relates to the effect of any potential delay in receiving medical records in order to secure the expert review and in finding a medical professional with knowledge of the particular long-term care setting to opine that negligence occurred.[121] This review is arguably necessary even when bringing a common-law negligence or breach of contract claim, as it appears tied to the status of the defendant as a health care provider and not to the type of claim being brought.

Long-term care is ever-evolving and new care models are still being created, making it challenging for a plaintiff to find medical professionals on point to not only the type of care at issue, such as wound care or falls, but also in the setting at issue, such as an assisted living facility or residential care home. The expert review statute accounts for filing suit without the expert review due to an imminent statute of limitations, but it also should allow for filing suit without the expert review due to an imminent death.[122]

IV. ANALYSIS

When determining how the current state of the law affects older adults, consider the following examples that highlight the

120. *Id.* § 145.682, subdiv. 3.
121. *See id.* § 145.682.
122. *See id.*

need for reform in the law to account for the vulnerability and disadvantages inherent in the law for an elderly claimant.

A. Example 1

Jane Doe is a resident of a nursing home; she falls during a transfer by staff from her bed to her wheelchair and breaks her hip. She is eighty-five years old and suffers from congestive heart failure and dementia. She is not a surgical candidate and returns to the nursing home for rest and rehabilitation. However, due to her immobility from the fracture, she contracts pneumonia and dies twenty days after the fall. She has two siblings in nursing homes out of state. She left no will. Her closest relative is one niece who was not involved with her care.

Some potential barriers to bringing any claim on behalf of Jane include the following: (1) none of the existing family members likely have standing to retrieve medical records to investigate the claim—her siblings are deteriorating in health themselves and they, like her niece, were likely not involved with her care prior to her death;[123] (2) it appears that a trustee must be appointed to even retrieve medical records,[124] yet securing the consent of the siblings in the nursing home will be a challenge—the niece will likely need to notify all other relatives at her same relational level to Jane,[125] meaning all other nieces and nephews, who may or may not consent to appointment—and a hearing will likely be required to appoint a trustee,[126] adding to the expense and public nature of the process; and (3) due to her multiple health conditions and the time span between the fall and death, isolating the fall as a reason for the cause of death (rather than her congestive heart failure) may be a challenge for the coroner and

123. *See* MINN. STAT. § 573.02, subdiv. 2 (designating the trustee in an action for death by wrongful act as the "next of kin"); 45 C.F.R. § 164.508(c) (2015) (including a list of required specifications for obtaining authorized disclosures of medical records); *see also HIPAA What to Expect*, *supra* note 68 (stating that authorization is obtainable but that inevitable delays in record requests are burdensome for elderly clients).

124. *See* Ortiz v. Gavenda, 590 N.W.2d 119, 122–23 (Minn. 1999) (citing Regie de l'assurance Auto. du Quebec v. Jensen, 399 N.W.2d 85 (Minn. 1987)) (discussing the requirement of an appointed trustee in order to bring a wrongful death claim).

125. *See* MINN. STAT. § 573.02, subdiv. 3.

126. *See* MINN. R. GEN. PRAC. 144.02.

the cause of death may not reflect the fall as a condition precedent to her decline.

B. Example 2

Frank Doe is sixty-six years old and receives services in an assisted living facility for his quadriplegia suffered during an accident when he was younger. He is also diagnosed with Type I diabetes. He receives two insulin injections per day. He relies on staff for frequent turning and repositioning as well as devices to float his heels off the bed. He developed wounds on his feet and could not move his feet and legs due to paraplegia. The wounds developed gangrene, and he required bilateral below-the-knee amputations. Frank receives Medical Assistance benefits. A notice of claim was given three months ago to the liability insurance carrier for the assisted living with no response.

Some potential barriers to bringing any claim on behalf of Frank include the following: (1) because Frank receives Medical Assistance benefits, any settlement or award that he receives must be disclosed to the county; he either becomes ineligible for Medical Assistance until his assets return to being under $3,000, or he creates a pooled trust that he believes will not be treated as a prohibited transfer for less than fair market value;[127] (2) due to his quadriplegia, he cannot describe pain in his legs from the wounds or the amputation, although he knows that the wounds are painful due to sensations and other factors; and (3) good faith insurance laws state that the insurance company provide contact information within ten days, but as a third-party claimant, Frank has little ability to force a response from the insurance carrier in order to keep the claim moving.

C. Example 3

Mary Doe resided in a memory care unit for help with her activities of daily living because of her frontal temporal lobe dementia. She resisted care because her mind could no longer regulate her actions. She was sexually assaulted by a staff member. She did not go to the hospital; therefore, no medical bills related to the assault were incurred. She if often non-verbal due to her dementia and her low cognitive ability to process information. It

127. *See supra* notes 103–05 and accompanying text.

was later learned that the employee sexually assaulted other residents due to lack of supervision of the employee. She signed a pre-dispute, binding arbitration agreement as part of the admission agreement three years ago.

Some potential barriers to bringing any claim on behalf of Mary include the following: (1) because she has dementia, she may not have a health care directive or financial power of attorney (or have the requisite capacity to appoint one now) granting an agent the authority to bring a claim on her behalf or retrieve her medical records;[128] (2) if she dies prior to bringing the claim, she may receive no monetary award since pain and suffering damages are not available to her after death and she incurred no medical bills due to the nature of the injury;[129] (3) if pain and suffering damages prevail, due to her lack of cognitive ability, she is not able to verbalize her pain and suffering as a result of the sexual assault and the incident was not witnessed;[130] (4) Mary would still need to give notice to Medicare and other health insurance companies, even though no medical bills were incurred, causing delay to the process with Medicare taking up to sixty-five days for an initial estimate of related payments;[131] (5) the case may be appropriate for punitive damages given the reckless disregard for the safety of residents by allowing multiple sexual assaults, yet punitive damages may be unlikely to be awarded in the arbitration process;[132] and (6) an expert may have little information to review in the memory care unit related to pain or otherwise, due to the resident being non-verbal, and depending on the license of the memory care setting, the documentation standards may be low, thus not yielding extensive information.

V. CONCLUSION

In many ways, the long-term care system in Minnesota is advanced and poised to meet the increasing demands of health care for the older population. However, injuries do occur and the law must facilitate accountability. Under the current laws, several barriers exist to investigating, bringing, and prevailing in a medical

128. *See supra* Sections III.A–.D.
129. *See* MINN. STAT. § 573.02 (2014).
130. *See id.*
131. *See supra* Section III.I.
132. *See id.*; *see also supra* note 74 and accompanying text.

malpractice action against a long-term care provider. This article highlights those barriers and raises awareness, at minimum. Beyond the minimum, it is hoped that some of the laws can be changed to better account for claims brought by older, vulnerable adults. The current laws send the wrong message to providers that even in the face of the most egregious injury, the claims may go away, not because the provider did no wrong, but because the barriers snuff out the voices of the residents or decedents. Public policy and the principles of justice demand better for long-term care residents and vulnerable adults.